maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Fertility Preservation

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Has the provider obtained a medical authorization for fertility preservation from MPC? ACTION REQUIRED: Submit documentation/approval letter to confirm benefit authorization. [If no, no further questions.]	Yes	No
2	Does the patient have impairment of fertility? [If no, no further questions.]	Yes	No
3	What is the reason for the impairment of fertility? [] Surgery (If checked, go to 5)		

If you have any questions, call:
1-888-258-8250

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	[] Radiation (If checked, go to 5) [] Chemotherapy (If checked, go to 5) [] Other (If checked, go to 4)		
4	Is a medical treatment or intervention affecting reproductive organs or processes causing impairment of fertility? If yes, please document the medical treatment or intervention: _____ [If no, no further questions.]	Yes	No
5	Has documentation been provided for clinical notes indicating treatment plan of the proposed fertility preservation services? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Does the prescriber attest that all FDA precautions/warnings, contraindications to treatment, and any Black Box Warnings have been considered? [If no, no further questions.]	Yes	No
7	Does the prescriber attest that all medications that are contraindicated in concurrent use with the requested medication will be discontinued? [If no, no further questions.]	Yes	No
8	Is the patient within reproductive ages of puberty to menopause? [If yes, no further questions.]	Yes	No
9	Is the patient in prepubertal age or insufficient time for oocyte retrieval for ovarian tissue cryopreservation?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250